

# AUSTIN SKIN

medical + surgical + cosmetic dermatology

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient  
Name:

Date  
of Birth:

MM / DD / YYYY

Patient's  
Full Address:

I authorize Austin Skin, LLC to:

**Send** copies of your medical record  
(or discuss information with) the  
provider/person/facility below.

**Receive** copies of your medical record  
(or discuss information with) the  
provider/person/facility below.

Name of Provider/  
Person/Facility:

Full  
Address:

Office  
Phone:

Office  
Fax:

Information to be disclosed:

Patient Progress Notes - Medical and Surgical  Pathology Reports  Pathology Slides  
 Laboratory Reports  Patient Photos  All Records

**Purpose of Request or Disclosure:** Article 449b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release."

Continuing Patient Care  Change of Physician  Personal  
 Insurance Purposes  Relocation  Other

**Restrictions:** Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information including the date on this authorization unless other dates are specified. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Austin Skin, LLC.

I have read the above foregoing Authorization for Release of medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative  
Signature:

Date:

MM / DD / YYYY

Printed Name of  
Authorized Representative:

**Parent/Guardian signature required for patients less than 18 years of age.**

Signature of  
Parent/Guardian:

Relationship:

Printed Name of  
Parent/Guardian:

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San Marcos, TX 78666

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